COMMUNITY SAFETY

CITY OF DURHAM

Crisis Response Pilot Plan Updates

Ryan Smith, CSD Director| January 2022

Agenda

Today's presentation will provide City Council with updates on:

- CSD's activities during the department's first six months
- Pilot plans for four areas we are ready to advance:
  - Crisis Call Diversion (remote response)
  - Community Response Team (in-person, unarmed response)
  - Co-Response (joint in-person response with DPD)
  - Care Navigators (follow-up)
- Anticipated timeline
- Outcomes and Evaluation plans
- Staffing and service levels with current resources

A shop owner is concerned about a man sleeping in the doorway of her business and who will not move when asked.

*This call comes in as a **Trespass***

A man is worried about a colleague who hasn't shown up to work today. When he saw her a few days ago, she was not acting like herself.

*This call comes in as a **Welfare check***

A woman is afraid that someone is breaking into her apartment through the ceiling. She has a history of calling 911 with hallucinations.

*This call comes in as a **Crisis***

Community-Informed: We have been conducting in-person resident interviews, focus groups and listening sessions. We also collaborated on a 2-day virtual Town Hall with SWTF. We have engaged 220+ residents so far.

Highly-Collaborative: We formed a multi-agency planning team with EMS, DPD, DECC, DFD, Alliance, CJRC, CAO, UNC School of Social Work, Housing for New Hope, RTI, & Recovery Innovations to plan pilots. We have also conducted multiple CIT ride-alongs & interviews with peer support specialists, community health workers & mental health professionals.

Data-driven: We analyzed 3 years of Durham 911 calls to better understand which calls are appropriate for our pilots. We also conducted a use of force analysis and built data tools that allow us to analyze calls by volume, frequency, location, risk level, and response time.

Evidence-based: We've taken time to learn from many US cities leading similar work, including Albuquerque, Austin, Atlanta, Charleston, Denver, Greensboro, Houston, Philadelphia, Portland, & San Francisco, among others. We're also part of a national cohort of 5 cities launching pilots this year.

Person in need of support

Our goal: **To connect people to the right care by sending the right response, across the spectrum of risk.**

Person in need of support

To meet this goal, we are designing new approaches and support at **3 key moments**: the call, response, and follow-up.

Connecting people to the right care starting from the point at which someone calls 911 to the warm handoff to those prepared to help meet the needs of our neighbors in crisis.

1 The call

Crisis Call Diversion (CCD)

2 In-person response

Community Responder Team (CRT)

Co-Response (CoR)

3 Follow-up

Care Navigators (CN)

CCD	CRT	CoR
CN		

We aim to be as far upstream in the process as possible. Integrating clinicians on the floor is crucial.
– Austin 9-1-1

There needs to be a holistic approach, starting with the appropriate triage of the call, so that it can be matched to the appropriate responding resource.
– Durham Fire

1
The call

Crisis Call Diversion (CCD)

2
In-person response

Community Responder Team (CRT)

Co-Response (CoR)

3
Follow-up

Care Navigators (CN)

Crisis Call Diversion (CCD)

Description

Embed licensed mental health clinicians into Durham's 911 call center to triage, assess, and respond to behavioral and mental health related calls for service that are non-emergent and non-life threatening.

Goals

1. Ensure callers experiencing mental or behavioral health crises are quickly connected to the right response and care based on their needs.
2. Divert appropriate behavioral and mental health related calls for service away from unnecessary in-person responses or interactions with the criminal justice system.
3. Reduce risk of harm when responding in-person to mental health crises.

Crisis Call Counselors embedded in our 911 call center will serve 8 major functions:

ASSESS
911 callers' needs, complete safety plans, and help identify the appropriate response.

DIVERT
non-emergent crisis calls that do not require an in-person response.

CONNECT
people to resources (incl. 988) to support with future mental health-related needs.

DISPATCH
Community Response Teams as appropriate.

CONSULT
with 911 dispatchers, providing information that can support better outcomes.

DE-ESCALATE
situations prior to the arrival of first responders.

SUPPORT
responders in the field as unanticipated mental health related issues arise.

FOLLOW UP
with callers after a crisis to check in and support linkage to any services.

How 911 behavioral health calls are handled can determine whether the incident ends safely, the person in crisis is arrested, or the person is connected to appropriate care.

– Pew, October '21, "New Research Suggests 911 Centers Lack Resources for Behavioral Health Calls"

New question for appropriate 911 calls:

"Are you aware or does it appear the person is in mental health crisis?"

IF YES: A counselor would conference in with the call-taker right away to listen through the rest of the protocol questions.

CCD Eligible call types

- Mental Health Crisis
- Suicide Threat
- Other calls involving a person with a known or suspected mental or behavioral health need

Crisis Call Diversion response

Exclusion criteria*

- Is a weapon present?
- Is the person in crisis exhibiting physically violent behavior towards themselves or others?
- Is the person in crisis under the influence of drugs/alcohol to the extent that a medical intervention may be needed?
- Is this a priority P call?

Co-Response /EMS response

*CCD Counselors could still support MH calls involving violence or weapons, but the goal would be **de-escalation**, not diversion.

Data on Durham Mental Health Crisis & Suicide Threat Calls

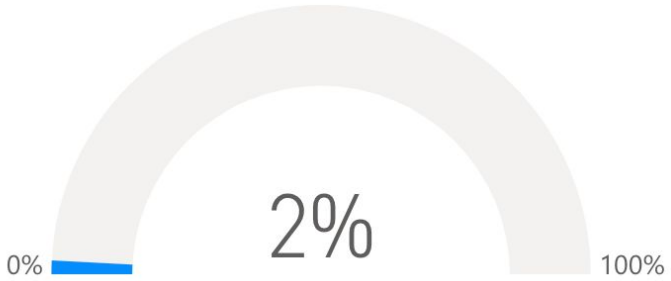
Calls Per Year

2,053

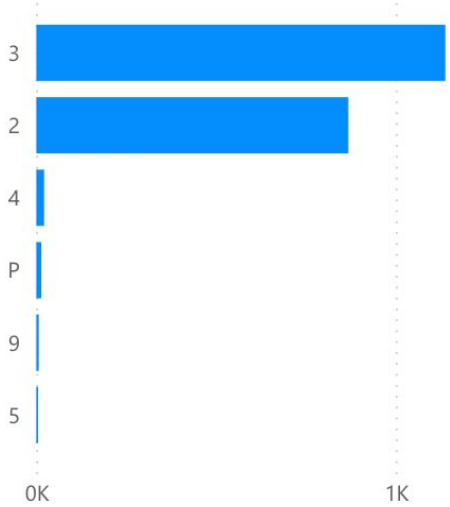
Calls Per Month

171

Share of All Calls



Calls Per Year by Priority



What is a priority level?
All calls are assigned a priority level by 9-1-1- dispatch:

P Potentially poses immediate threat to life (highest priority)

2 Status of threat is unknown. Event occurred 5 min ago or less.

3+ No known threat to life or property. Event occurred greater than 5 minutes ago

Hours spent by officers resolving calls	Percent of calls resulting in **Use of Force**	Percent of calls resulting in **Arrest**	Percent of calls to **Non-Emergency Line***
1,941	**0.05%**	**0.03%**	up to **25%**

**Data on calls that come through our non-emergency line also include some instance where our system could not import data directly from a 911 call.*

HOUSTON

Launched in 2016

2016 – 2020

7,400+ calls diverted from police (5.8% of total CIT calls; over 11,000 hours of police time saved)

Increased staff
9 clinicians

Now operates
24/7

Est. cost avoidance of diversion
$477,818 per year

The cost of their CCD program at the time was $460,000

AUSTIN

Launched in 2020

In 1 month

Responded to 742 calls (84% of those diverted from police)

Increased staff
18 clinicians

Now operates
8 – 12am Mon-Fri
10 – 8pm Sat

Added question to all 911 calls

"Are you aware or does it appear the subject is in mental health crisis?"

Plans to add Advanced Pediatric Nurse who can write prescriptions for psychiatric medications

CHARLESTON

Launched in 2020

In 1 day

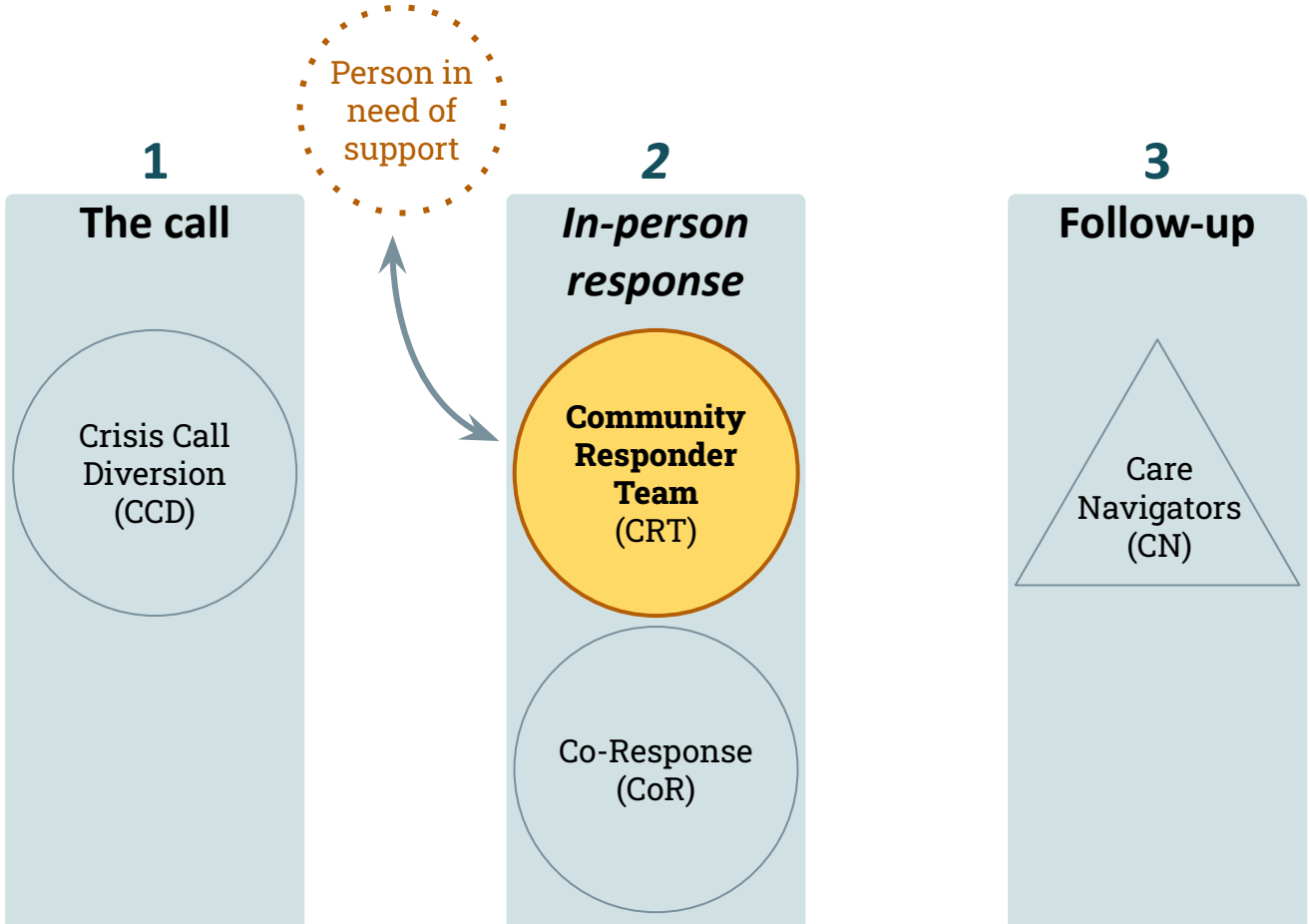
Respond to 4 calls (as many as 7)
Call intake represents about 60% of total eligible calls

Counselors are beginning to assign themselves to responding to 911 calls through CAD.

Shows greatest success with 1st party calls (when the person who is undergoing the crisis calls 911)

Police & Fire are the default for when things have gotten really bad, but are typically poor instruments for dealing with chronic issues like mental health and addiction.
– Durham Police Officer

What happens when you give lots of social workers police radios is they recognize that a lot of the issues coming through 911 do not need the traditional response.
– Denver STAR clinician



Community Response Teams (CRT)

Description

Provide rapid, trauma-informed care for 911 calls for service involving non-violent behavioral and mental health needs and quality of life concerns, including calls involving the needs of people who are unsheltered, by dispatching teams of unarmed, skilled and compassionate responders as first responders.

Goal

Send the right response based on people's needs and, by doing so, reduce law enforcement encounters and unnecessary emergency room use.

IDENTIFY

appropriate 911 calls that will receive an unarmed response:

How we've identified appropriate calls:

- ✓ From evidence in other cities responding to these calls;
- ✓ From input from Durham behavioral health providers, residents and first responders;
- ✓ From a deeper dive into data specific to Durham calls;
- ✓ From observing similar calls through ride-alongs with DPD

I want a response that centers and responds to people's needs appropriately.

– Durham resident

*Common calls eligible for unarmed responders **in other cities***

Common eligible calls: Assist; Disturbance; Intoxicated Person; Mental Health Crisis; Suicidal Ideation; Panhandler, Public Indecency; Trespass; Unsheltered Person; Welfare Check

Common exclusion criteria: Possession of weapon; Physical violence; Imminent threat to themselves or others; Serious medical needs; Criminal activity

IDENTIFY **DISPATCH**

teams of three unarmed, skilled responders through 911:

1 Licensed Clinician	2 Peer Support Specialist	3 Advanced-EMT
Someone who has 3 years of post-graduate experience and over 1,000 hours of supervised work	Someone who knows the community, has relevant lived-experience, and has been trained as a specialist	Someone who has been trained to provide advanced life support care
Role includes: Screening and assessing people experiencing crisis with mental health and substance use; providing therapeutic interventions, case management, and personalized services that connect people to community-based mental health providers.	**Role includes:** De-escalating situations, promoting engagement in care, fostering relationships between residents and other community responders, and making connections with residents to gain trust and move them to be open to care.	**Role includes:** Assessing people for potential medical emergencies, providing life support and pre-hospital emergency medical care to individuals, and helping identify underlying medical needs that may present initially as mental health needs.

IDENTIFY **DISPATCH**

Why multi-person teams?

Mitigate safety risks for unarmed responders	Match the needs of a person with the right expertise	Support others on the scene involved in the crisis
A team-based approach provides added safety compared to dispatching a single responder. Additionally, each position brings different skills and experiences that improve situational awareness.	A multi-disciplinary team is better positioned to respond to wider range of needs that a person in crisis may have. Additionally, teams are more likely to have one team member who can connect with the person.	A team-based approach means responders have greater capacity to engage with others present during the crisis, especially family members and others who have also experienced trauma.

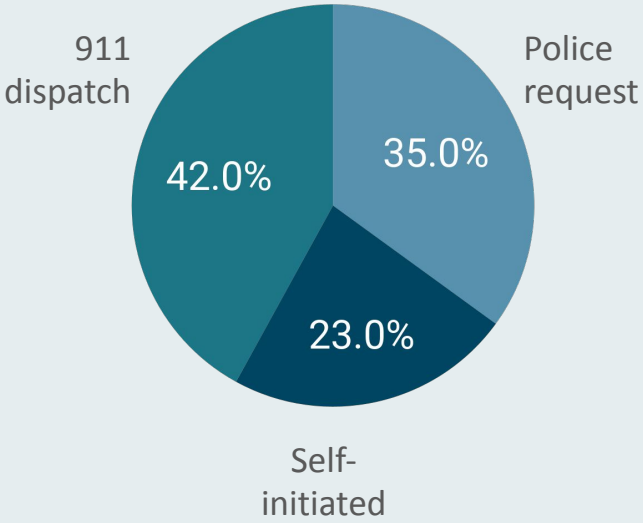
IDENTIFY **DISPATCH**

CRT teams will receive calls through 3 primary avenues:

1. **Direct dispatch** from 9-1-1 as first responder;
2. Request for assistance **from call takers or other first responders** who arrive to a call and realize that CRT is the more appropriate responder;
3. **Self-initiated** calls through a proactive community presence

Example: Denver STAR

call assignment sources



IDENTIFY → DISPATCH → **ARRIVE**

on the scene in less than 30 minutes from time of dispatch.

"We are often able to arrive on scene faster than law enforcement because for them these are lower priority calls."
– Denver STAR

Arrival Appearance:

- Responders will arrive in vehicles distinguishable from other responders.
- Vehicles will have lights for safety, but not sirens.
- Responders will be dressed in plain clothes with a shirt that clearly identifies them as community responders.

Response-time stats from other cities with unarmed responders:

City	*Avg response time*
Denver	**28 minutes**
San Francisco	**16 minutes**
Atlanta	**18 minutes**

IDENTIFY → DISPATCH → ARRIVE → **DELIVER**

person-centered, trauma-informed care.

[I want] somebody to come diffuse the situation. They would show love, compassion, understanding, patience… to be there physically, to sit down and talk with you.
– Durham resident experiencing mental and behavioral health challenges

One reason people are afraid of police, besides documentation, is language barriers. They'll ask for personal information and many are afraid they'll be investigated and get benefits removed.
– Durham resident from an immigrant community

I want to know that unarmed responders will not be accompanied by an armed officer and for there to be clear understanding in the community when a transition to an armed response is going to happen.
– Durham resident

[I want] someone who can relate to being homeless, know how to treat them, how to ask questions. They'd come to check on you, see what's going on, see if you're on medication, good with housing… the whole nine.
– Durham resident with housing insecurity experience

Harm Reducing

Approaches that **honor the dignity of every person** encountered. Residents underscored centering people's needs, commiting to nonviolent resolution, and respecting individual needs and choices about their health.

Accessible & Inclusive

Approaches that are **welcoming, respectful, and culturally competent.** Residents emphasized the need to account for diverse backgrounds, language barriers, and multiple ways for people to access services.

Reliable & Predictable

Approaches that embed **transparency, follow- through, and follow-up.** Residents highlighted the need for consistency: *when* will services be offered, *who* will show up, and *how* will information be shared?

Familiar & Empathic

Approaches that provide **compassionate understanding and opportunities for frequent interaction** with community members. Residents reiterated the significance of sharing lived experiences in the building of trust.

IDENTIFY > DISPATCH > ARRIVE > DELIVER > **TRANSPORT**

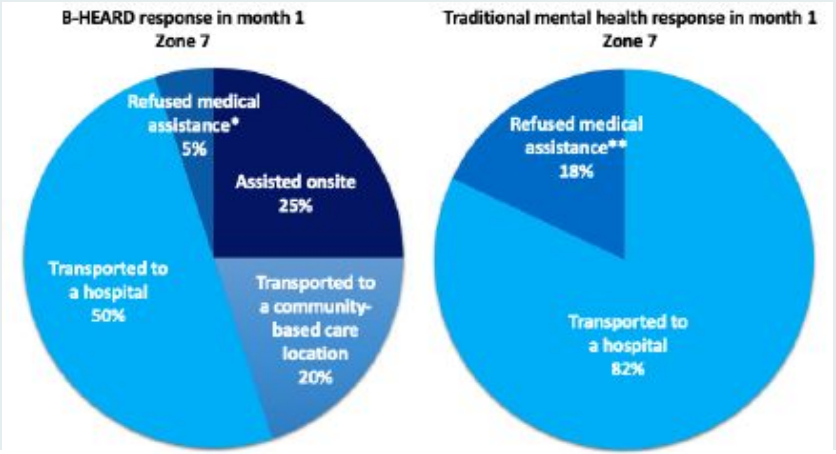
people to the appropriate community-based care:

Wherever possible, CRT will seek to resolve issues on scene in community. However, when people want and need to go to community-based care options, CRT will transport them.

During the pilot, teams will transport people:

- **To:** non-emergency facilities (e.g. Durham Recovery and Response Center, shelters, etc.)
- **Not to:** private residences, Emergency Room (EMS will be requested), or involuntary commitments

Early results from NYC show fewer people are transported to hospitals and more people accept care from unarmed responder teams than from police/EMS:



IDENTIFY > DISPATCH > ARRIVE > DELIVER > TRANSPORT > **FOLLOW UP**

with residents 48 hours after a crisis.

Follow-up emerged as an essential part of connecting people and families experiencing crisis to the right care:

- Other cities with unarmed responders all named follow-up as crucial;
- Durham behavioral health providers, first responders and residents have consistently lifted up the need for adequate follow-up after crises, both with the person in crisis and their families.

To meet this need, we plan to pilot dedicated Care Navigator teams (described later in this presentation).

It's not just about showing up at the scene. It is also about what happens next. It's about follow-up. That is even more important than showing up. You have to make sure than she gets the right type of help that she needs.

– Durham resident

Safety Measures

✓ **Exclusion criteria**
For certain risk indicators

✓ **Visible to dispatch**
Automatic vehicle location

✓ **Police radios**
Ability to call for police backup

✓ **Training**
Prior to responding to calls

See Appendix for more details on training.

You could argue that you have community workers already doing this work, without the benefit of a dispatch and police radio — I could be gone for three days before anyone noticed. This is safer than any case management I've done in the community before [the Denver STAR program].

Safety stats from other cities:

City	*Calls*	*Calls for backup*
Denver	**1,700** total	**0**
San Francisco	**700** / month	**2%** (no arrests or violence as a result of calls for back-up)
Eugene	**17,000** / year	**2.3%**

*A review of 7 community responder programs by the Council of State Governments found **0.014% out of 23,500 calls required police backup**.*

Proposed eligible calls for Community Response Teams

Initial eligible calls (first 6 months)	**Calls for future consideration**
When the pilot starts, we propose dispatching Community Response Teams to these call types:	We are considering further exploring the following additional call types for inclusion in a later phase. Some of these may be best explored initially through a co-response model.

- Nonviolent mental health crisis
- Suicide threat
- Trespass
- Welfare check
- Intoxicated person
- Assist
- Follow-up
- Panhandling
- Indecency
- Verbal Disturbance

- Disturbance
- Drug use
- Prostitution
- Noise Complaints

CRT calls must ***not*** meet these exclusion criteria:

- The person is in possession of a weapon
- A person is under the influence of alcohol or drugs to the extent requiring a medical intervention (e.g. overdose)
- A person at imminent risk of hurting others
- High priority calls that potentially pose immediate threat to life (Priority P)

Data on Proposed Phase 1 Eligible Calls

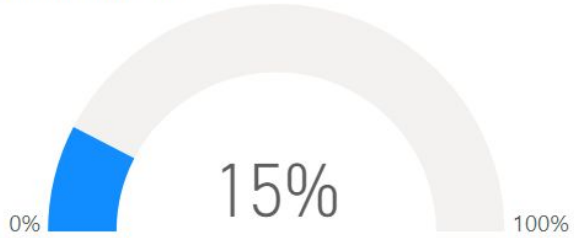
Calls Per Year

19,023

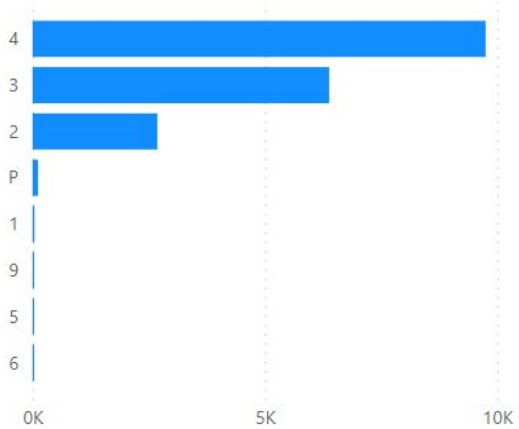
Calls Per Month

1,585

Share of All Calls



Calls Per Year by Priority



What is a priority level?
All calls are assigned a priority level by 9-1-1- dispatch:

P Potentially poses immediate threat to life (highest priority)

2 Status of threat is unknown. Event occurred 5 min ago or less.

3+ No known threat to life or property. Event occurred greater than 5 minutes ago

Hours spent by officers resolving calls	Percent of calls resulting in **Use of Force**	Percent of calls resulting in **Officers as Victims**	Percent of calls resulting in **Arrest**	Percent of calls to **Non-Emergency Line***
11,655	**0.05%** (10)	**0.05%** (10)	**0.13%** (13)	up to **39%**

Durham is not alone in our interest in developing unarmed responder teams for some 911 calls. Other US cities are already showing us this can be done in ways that meet the needs of residents in crisis and are consistent with first responder safety. We have been learning from 8 cities over the past 6 months. **Here are examples from 3 cities already doing this work:**

DENVER

Launched in 2020

STAR

In first 12 months
Responded to 1,700 calls

Top calls
Welfare Check, Trespass, and Assist

Increased staff
From 1 team to 6

Now operates
7 days/wk
32 sq.mi. area

Model
2-person team (A-EMT + Clinician)

SAN FRAN

Launched in 2020

Street Crisis Response Team

Nov 2020 to Oct 2021
Responded to 4,616 calls

Top calls
Behavioral health distress
(now responding to 58% of eligible calls)

Increased staff
From 1 team to 7

Now operates
24/7 citywide

Model
3-person team (Community Paramedic, Clinician & Peer Specialist)

ATLANTA

Launched in 2020

PAD

In first 9 months
Responded to 747 calls

Top calls
Basic needs, mental health & disturbance

Increased staff
From 11 to 35 staff

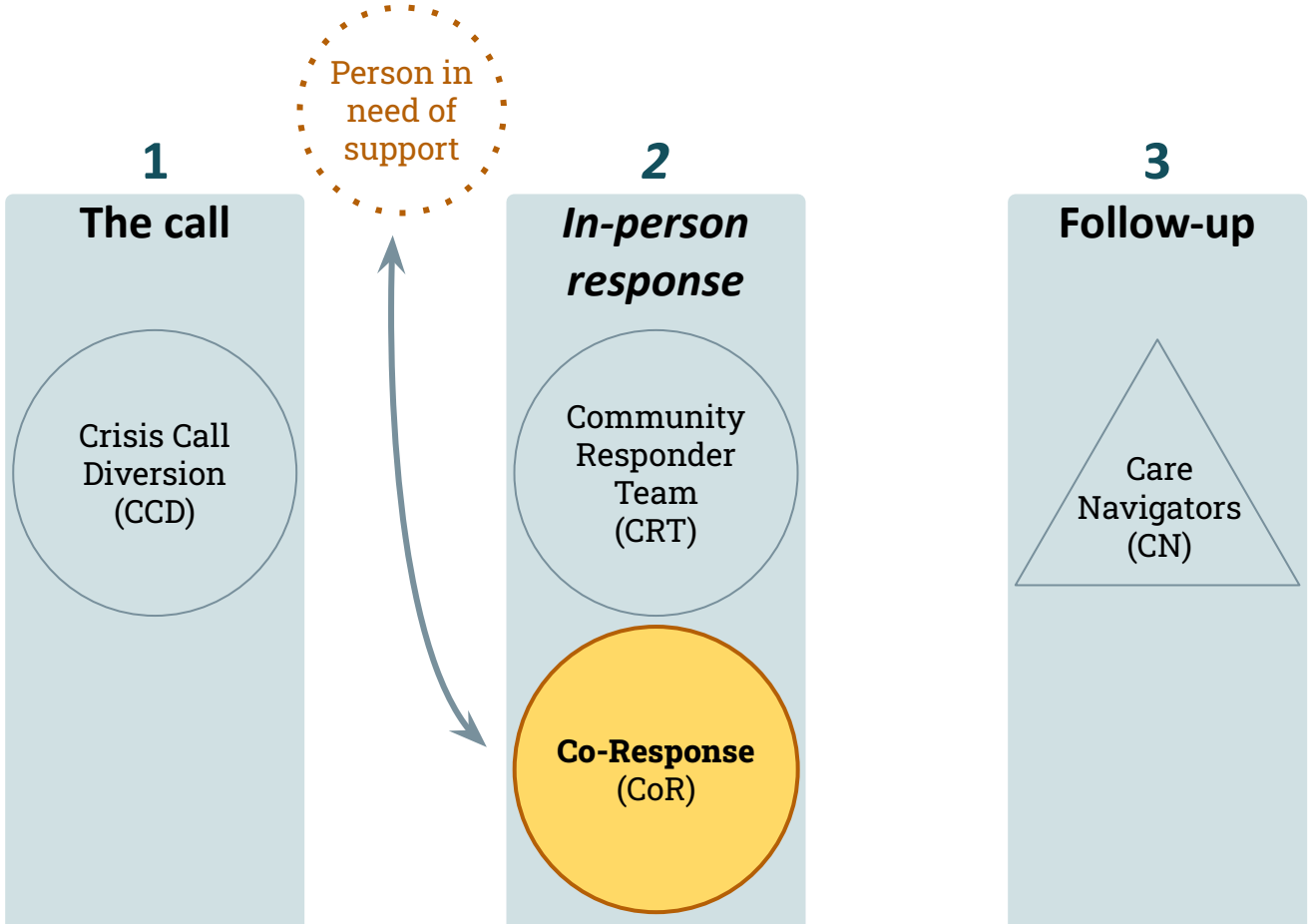
Now operates
M-F, 7am – 7pm

Model
Unlike other cities, utilizes 311, not 911

2-person team (Harm Reduction Specialists – Bachelor's in Social Work)

CCD	CRT	CoR
CN		

One can't expect every person to be the best mental health crisis responder and the person kicking down the door and carrying out several other police responsibilities all at the same time. It takes so many different facets of personality, training, and abilities to respond to these calls that one person can't be all of those people.
– Durham Police Officer



Co-Response (CoR)

Description

Send a Licensed Clinician and Peer Support Specialist with a CIT police officer to respond to *highest risk calls* involving mental and behavioral health needs.

Goals

1. Send the right response to a wider range of crisis calls regardless of priority level, and
2. More safely explore some calls types to see if they might be appropriate for unarmed responses in the future.

Co-Response would entail a joint-response from Durham Police and Community Safety departments.

DISPATCH

9-1-1 would dispatch a DPD CIT officer, along with a 2-person team from CSD (a licensed clinician and a peer support specialist) where there is a higher risk of violence.

ASSESS

CIT officers would assess the scene for safety.

DE-ESCALATE

The clinician and peer support specialist would support the CIT officer in de-escalation.

DELIVER

Clinician and peer support team will deliver therapeutic de-escalation and harm reduction responses to persons in crisis. Team also works with families and others on scene.

CONNECT

The Co-Response team will work together to assess needs and connect persons in crisis to community-based care where appropriate.

SUPPORT

In an involuntary commitment, the team will support family members present and will continue to support the resident in crisis throughout the involuntary commitment process, including as an advocate at the hospital.

Proposed eligible calls for Co-Response (CoR)

Initial eligible calls (first 6 months)

When the pilot starts, we propose dispatching Co-Responders to the following calls:

- Crisis Response Team (CRT) calls where one or more exclusion criteria are present;
- Calls under future consideration for unarmed responders:
  - Disturbance, Family & Domestic Disturbance
  - Drug use
  - Prostitution
- Calls for involuntary commitments;
- Other calls for service where a mental or behavioral health need may be present but not currently eligible for unarmed responders, including domestic violence

Calls for future consideration

Based on results from the first six months of each pilot, some calls eligible for CoR under phase 1 could move to CRT teams.

- Continue to respond to CRT calls where one or more exclusion criteria are present;
- Continue to respond to calls for involuntary commitments;
- Continue to respond to calls for service where a mental or behavioral health need may be present but are not eligible for unarmed responders;
- Depending on what we learn from the first six months, CoR may continue to respond to Disturbance, Drug use, and Prostitution calls, or only when these calls meet exclusion criteria for CRT.

Data on calls initially eligible for Co-Response

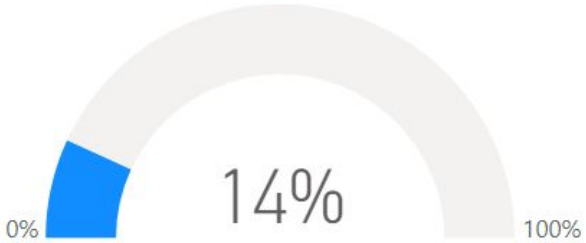
Calls Per Year

17,177

Calls Per Month

1,431

Share of All Calls



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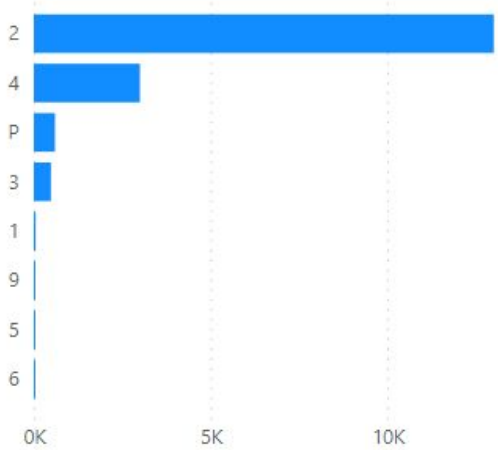

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3+ No known threat to life or property. Event occurred greater than 5 minutes ago

Est. hours spent resolving calls	Percent of calls resulting in **Use of Force**	Percent of calls resulting in **Officers as Victims**	Percent of calls resulting in **Arrest**	Percent of calls to **Non-Emergency Line***
6,962	**0.13%** (23)	**0.09%** (15)	**0.21%** (36)	up to **16%**

GREENSBORO

Launched in **2021**

PURPOSE

Respond to 911 calls involving individuals in mental crisis or having mental health issues, and follow up with those individuals to connect to services.

PERSONNEL

Two-person teams comprised of 1 Officer and 1 Counselor who ride together; Officers assess scene for safety before counselors begin interaction. OEI hired 9 staff who work with 9 sworn GPD staff.

HOURS OF OPERATION

M-F, 8am – 10pm
Crisis Counselors also work on-call overnight, weekends, and holidays

Greensboro's Behavioral Health Response Team is a joint response between the Office of Equity and Inclusion (OEI) and Greensboro Police Department.

Between January to June 2021, this team…

- Responded to 2,800 calls (70% of mental health calls), representing 961 people.
- Conducted 739 follow-ups and 405 hours of case mgmt.

CO-RESPONSE:

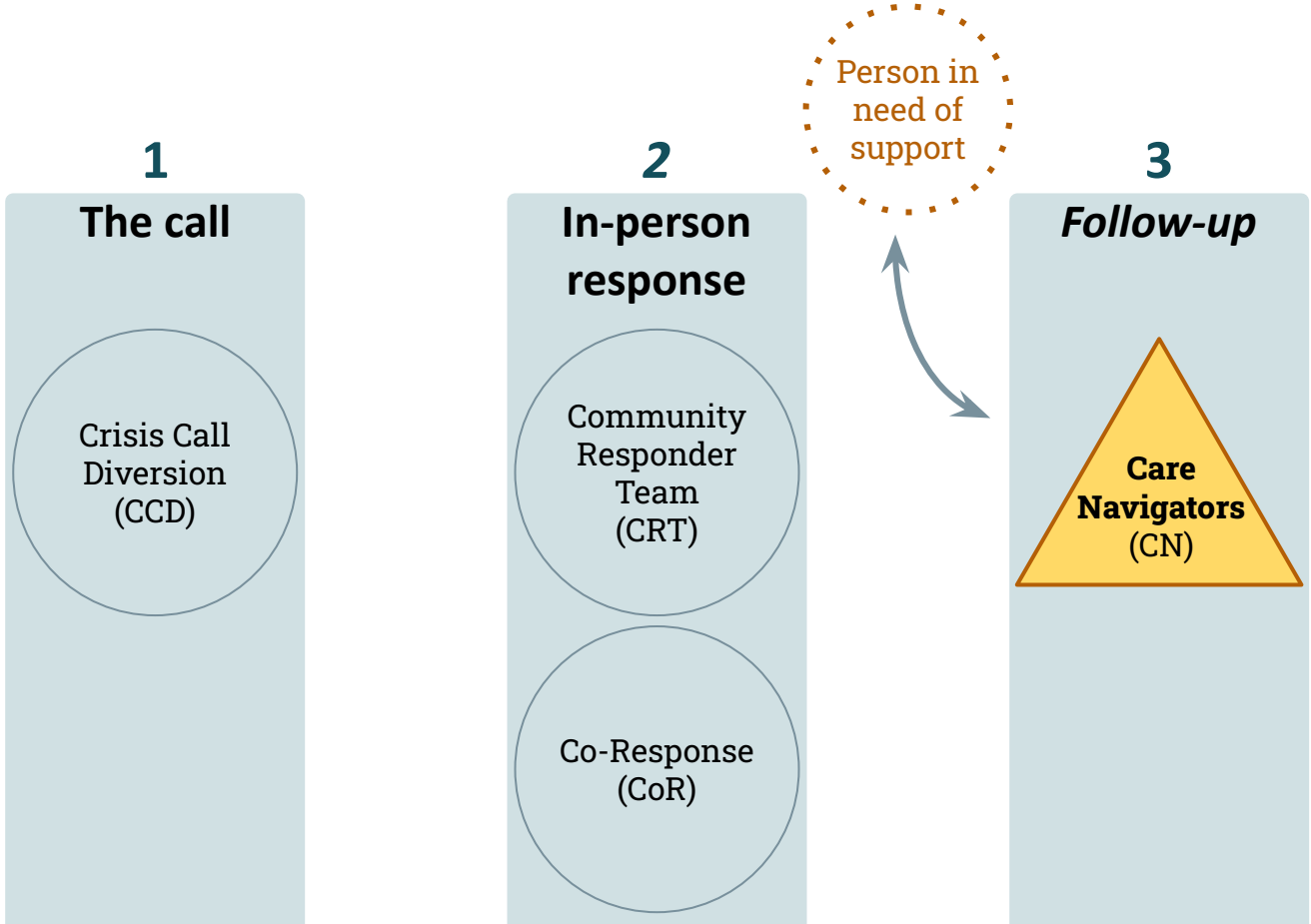
What we know about the model

- Started in the US in early 1990s
- Substantial variation in definition and delivery of co-responder teams across communities (e.g. can be ride-along, ride-separate, or remote support).
- Insufficient research on its efficacy; however, evidence suggests Co-responder programs may:
  - facilitate better connections to behavioral health services;
  - improve de-escalation and experiences of people in crisis;
  - support diversion from the criminal justice system, and reduce strain on medical facilities.

CCD	CRT	CoR
CN		

Our initial response to mental health crises is fair / good, but we could use improvement with continuum of care and more clinicians/social workers.
– Durham Police Officer

Ensuring people are connected to someone who can help is so important. That is what can set this apart and make a real difference.
– Durham Behavioral Health Provider



Care Navigators (CN)

Description

Two-person teams of a Peer Support Specialist and Licensed Clinician provide in-person or phone-based care within 48 hours of initial encounter with crisis response teams, and continue follow-up until the resident is connected to the care they need and want.

Goal

Through follow-up, increase the likelihood that people connect with community-based care, reduce unnecessary use of the emergency room, and decrease the number of people who experience multiple crises.

Care Navigators: Core pilot elements

Families need help too, so they can learn how to deal with this crisis next time ... If you follow up with families, then you can learn about the social and family history, so you can better support the person in crisis.

– Durham resident

In-person and phone-based care within 48 hours of initial encounter

2-person teams	CRT + CoR follow-up	Continuation of care	Respond in pairs	Multiple check-ins
Navigator teams will be made up of 1 Community Health Worker/Peer Support Specialist and 1 Licensed Clinician.	Navigators will follow up with people who meet with our Community Responders, Co-Responders, or even Crisis Call Counselors, if requested. They will also follow up with families.	CRTs and CoR teams will inform Navigators about each person's needs. Navigators strive for a warm handoff to ensure linkage to care and to minimize people having to retell their story.	When following up in person, Navigators will respond in pairs.	Based on each person's needs, Navigators may check in multiple times, ranging from 1 week to 3 months.

SAN FRANCISCO

Launched in **2021**

PURPOSE
Link people to the right care following a crisis.

PERSONNEL
Two 2-person teams comprised of 1 Community Health Worker and 1 Licensed Clinician; planning to increase to 4 teams

HOURS OF OPERATION
M-F, 7am – 6pm

San Francisco's mobile crisis team is supported by an **Office of Coordinated Care**, where staff provide follow-up and linkage support to people within 24 hours of the initial encounter.

In September 2021, this team…

- Followed up with 59% of clients;
- Connected 34% of clients with an existing provider or treatment facility;
- Followed up directly with 33% of clients;
- Were unable to locate 27% of clients

Role of CCD Counselors in Follow-Up

Following up with callers after a situation led them to call 911 is crucial to ensuring people are connected to the right care.

After the initial phone call, Crisis Call Counselors will follow up with people:

Within 2 hours

if the situation involves any current threats to safety.

Intervention

Within 7 days

to confirm if a caller was successful in accessing a referral that CCD provided.

Connection

Within 2 weeks

for situations that involve a mental health concern and where the Counselor identified a potential for a future mental health crisis.

Prevention

If people would like in-person follow up, counselors will engage Care Navigators.

When can we expect to see pilots launched in Durham?

JULY 1, 2021 **Launch Community Safety Department**

PLANNING (July-Dec '21)

JUL - OCT
Hire core administrative personnel

AUG - JAN
Engage Durham community members, local professionals, and programs in other cities

SEP - JAN
Form and lead multi-agency planning team

PRE-LAUNCH (Jan - Jun '22)

JAN - FEB
Hire, onboard, and train Operations Administrator and Clinical Manager

JAN - FEB
Develop and post all positions to begin recruitment

MAY - JUNE
Complete hiring and training remaining staff

JUNE - JULY
Finalize pilot protocols with team

IMPLEMENTATION

JUN - JUL 2022
Launch all four pilots

The change we anticipate

▲ **Law Enforcement Capacity**
For focusing on violent crime

▲ **Comfort calling 911**
For MH/QOL calls

▲ **Resident confidence**
We will send the right response

▲ **Connection to Care**
For residents with unmet needs

▼ **Law Enforcement Encounters**
For mental & behavioral health

▼ **Arrests or citations**
For calls involving MH/QOL needs

▼ **Emergency Room use**
For mental/behavioral health calls

▼ **DECC time on repeat callers**
From residents with MH needs

Things we want to better understand through pilots*

Identifying appropriate calls
Do we have the right protocol?

Personnel
Do we have the right team makeup based on the needs of callers?

Familiarity
What aspects of this design principle are most important and why?

Mitigating burnout
How can we support & attend to the wellness needs of first responders?

Staffing for follow up
What level of staffing is required?

Rotations
Do the benefits of staffing rotations outweigh the challenges they present?

Sharing data that matters
How can we share data between crisis responders & service providers?

Appearance
What type of attire and vehicle markings establish trust & credibility?

**This is just a partial list of aspects we aim to better understand through our pilots.*

How we will determine impact

✓ Third Party Evaluations

Supported through external grants

RTI INTERNATIONAL

UNC SCHOOL OF MEDICINE Center for Health Equity Research

✓ Mixed Methods

Data and stories that matter and that can help us understand what is working, what is not, and why. Planned methods include, but are not limited to:

- Asset-based survey approach with 800 residents (oversampling Black, Latinx and sexual and gender minorities) to better understand perceived needs and to inform implementation plans
- A community participatory approach that collaborates with residents to think about and make sense of data collected
- In-depth interviews and focus groups with people who have interacted with one of the crisis response pilots.

Transparency + Accountability

✓ Publish monthly metrics on website

Including, but not limited to, the following:

Number of calls responded to by call type	**Average Response time**	**Call outcomes**	**Follow-up rate & outcomes**
Percent of calls for back-up & outcomes	**Call origin (911, referral, self-initiated)**	**Resident satisfaction with responder**	**Percent of people who accept services**
Client characteristics	**Type of services requested by client**	**Officer hours saved via diversion**	**Percent of eligible calls responded to**

✓ Ongoing Community Engagement

To understand residents' experiences with alternative responses and how to refine and improve the models.

SCOPE | **No Additional FTEs (7 remaining CSD vacancies) + 3 Grant-funded positions**

	Crisis Call Diversion	Community Responder Team	Co-response Team	Care Navigator
Pilot staffing	1 clinician	2 teams (5)	2 clinicians	1 team (2)
Percent of total calls during hours of operation	33%	61%	57%	N/A
Hours of Operation (based on call volume)	M-F, 2-10pm	M-F, 8am-11pm	M-F, 2p-10p (1) F-M, 2p-12a (1)	M-F, 10am-6pm
Percent of eligible calls covered	**Appx. 33%**	**8% - 22%**	**10% - 18%**	**TBD**
Police Hours Saved	**Appx. 524**	**932 - 2,564**	**N/A**	**TBD**

Thank you.

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Follow our progress at DurhamNC.gov/4663/department-updates